UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

MICHAEL R. HAMLIN,	)	
	)	
Plaintiff	)	
	)	
v.	)	Civil No. 03-169-B-W
	)	
PRISON HEALTH SERVICES, INC., et al.,	)	
	)	
	)	
Defendants	)	

ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION (DOCKET NO. 114) AND MOTION TO STRIKE (DOCKET NO. 134) AND RECOMMENDED DECISION ON MOTIONS FOR SUMMARY JUDGMENT (DOCKET NOS. 128 AND 130)

Michael Hamlin, a prisoner at the Maine State Prison, has brought suit against various entities based upon their alleged failure to provide him appropriate treatment for his medical condition, identified by Hamlin as Hepatitis C virus (HCV). The two remaining defendants, Prison Health Services, Inc. (PHS) and Correctional Medical Services, Inc. (CMS) have now moved for summary judgment. (Docket Nos. 128 & 130). I now recommend the court **GRANT** their motions. Also before the court is Hamlin's motion for preliminary injunction (Docket No. 114) and his motion to strike the affidavit of Celia Englander (Docket No. 134). I now **DENY** both motions.

Hamlin's Motions

On August 24, 2004, Hamlin filed a motion that he styled as a motion for preliminary injunction (Docket No. 114). Upon initial review of the motion, I determined that Hamlin was seeking an outside medical examination including a liver biopsy by a medical professional of his own choosing. I felt that this was in the nature of a pretrial

discovery request and scheduled a phone conference with all parties. As a result of that conference I entered an order regarding the transportation of Hamlin to an outside medical provider (Docket No. 121) and reserved ruling on the ultimate merits of the motion. A small contretemps arose vis-à-vis transportation issues, involving the Department of Corrections, CMS, Hamlin, and the court. I ultimately issued an order clarifying my original order in response to CMS's motion to amend that original order. (See Docket Nos. 122, 123, 124 & 125). As a result of that exchange, Hamlin was given the opportunity to arrange for an independent medical examination with a physician of his own choosing subject to the requirement that he file a specific affidavit with the court. Once Hamlin filed the affidavit, I indicated that I would order the Department of Corrections to transport him to the examination, if the paperwork he submitted was in proper order. Hamlin was given until October 8, 2004, to make those arrangements which he represented during the phone conference would be made by his parent and would be paid for out of private funds. He has never filed the appropriate affidavit with the court. Therefore, I am now denying his request that he be transported to an independent medical examination, treating the motion for preliminary injunction as a discovery request. The discovery deadline in this case expired on November 24, 2004.

Hamlin's second motion is an attempt to strike the affidavit of Celia Englander filed in support of defendants' motions for summary judgment. Hamlin believes that Englander's credibility and credentials are suspect and therefore her affidavit should be stricken. Certainly Hamlin is free to challenge the credibility of defendants' statements of material fact supported by Englander's affidavit by relying upon other facts, properly supported by admissible record citations, that tend to show that there is a genuine

material dispute about the facts asserted by Englander. However, the unsupported and conclusory allegations he makes in his motion regarding Englander's credibility are not grounds to strike another party's affidavit from the record. His motion is denied.

Summary Judgment Standard

Summary judgment is appropriate only if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). If the defendants meet this burden, Hamlin must "produce specific facts, in suitable evidentiary form, to establish the presence of a trialworthy issue." Triangle Trading Co. v. Robroy Indus., Inc., 200 F.3d 1, 2 (1st Cir. 1999) (citation and internal punctuation omitted). I view the record on summary judgment in the light most favorable to Hamlin, the nonmovant, drawing all reasonable inferences in his favor. Nicolo v. Philip Morris, Inc., 201 F.3d 29, 33 (1st Cir. 2000).

The fact that he is a pro se plaintiff does not free Hamlin from the pleading burden set forth in Rule 56. See Parkinson v. Goord, 116 F.Supp.2d 390, 393 (W.D.N.Y.2000) ("[P]roceeding pro se does not otherwise relieve a litigant of the usual requirements of summary judgment, and a pro se party's bald assertions, unsupported by evidence, are insufficient to overcome a motion for summary judgment."); see also Sirois v. Prison Health Servs., 233 F.Supp.2d 52, 53-55 (D. Me. 2002). Thus, the defendants' material facts that are properly supported with record citation are deemed admitted pursuant to District of Maine Local Rule 56(e) if Hamlin failed to properly refute them.

The summary judgment record in this case consists of PHS's thirteen paragraph statement of material facts (Docket No. 129), CMS's forty-six paragraph statement of material facts (Docket No. 131), Hamlin's response to PHS's statement of material facts and Hamlin's own statement of additional facts, paragraphs 14 through 45 (Docket No. 136), PHS's reply to those additional facts (Docket No. 139), and finally, CMS's reply statement of material facts (Docket No. 142). Although Hamlin has done a creditable job responding to these motions within the confines of Local Rule 56, conspicuously absent is his response to CMS's initial statement of material fact. I can only conclude this is so because Hamlin chose to rely instead upon his motion to strike the Englander affidavit rather than responding to each of the paragraphs contained within CMS's statement of fact. Many, although not all, of CMS's statements are supported by citation to the Englander affidavit. Furthermore, some of CMS's statements of fact are disputed in Hamlin's own statement of additional facts. To the extent that Hamlin has presented statements of fact properly supported by record citation,[1] I have credited all of his disputed facts in analyzing these motions for summary judgment.

[1] Hamlin's affidavit, the primary source of his record citations, includes a number of paragraphs that contain hearsay or recite allegations based upon Hamlin's information and belief. The defendants deny these assertions, to the extent Hamlin incorporates them into his statement of additional material facts, on the basis that they contain inadmissible evidence. I have generally sustained those denials and excluded inadmissible hearsay, conclusory statements, and argumentation from this recitation of facts. Hamlin also appears to rely upon three affidavits filed in an unrelated case, Sherwood v. Prison Health Services, CV-02-211-DBH, filed in this court on October 11, 2002. To the extent those affidavits are witness statements under oath based upon personal knowledge, they would not be hearsay. Unfortunately, Hamlin does not cite to specific paragraphs of those affidavits and he did not attach the affidavits to his own pleadings. I independently obtained copies of the affidavits to review because Hamlin's pleading clearly identifies the documents upon which he relies. However, I cannot find in those affidavits record support for all of the allegations that Hamlin makes in his affidavit. Two of the affiants Hamlin relies upon, Sherwood and Morong, filed relatively brief affidavits accompanied by a copy of the Maine Human Rights Commission filing they made in their charge that PHS retaliated against them in violation of the Maine Whistleblowers' Protection Act. All the papers attempt to establish is that those affiants had reasonable cause to believe that they had observed conduct that constituted (a) violations of laws or rules adopted under the laws of Maine or the United States and (b) conditions and practices that put at risk the health or safety of other individuals. The affidavits do not spell out what those circumstances might have been vis-à-vis the issue of HCV treatment for Hamlin or any other inmate. The third affidavit, briefly referenced by Hamlin, that of

Statement of Facts

The crux of Hamlin's case is that he should have been tested and received treatment for his HCV infection in a timely manner because of his high risk of HCV infection. (Hamlin Aff. ¶ 45.) He also alleges that from November 1, 1999, until March 31, 2003, PHS and Englander did not have any program in place to provide "further testing for HCV when warranted," inform inmates when they tested positive for HCV, or provide HCV treatment to inmates. (Id. ¶ 16.) Hamlin makes additional allegations about how he contracted HCV, the adequacy of testing and treatment he received, and the ongoing harm he has suffered. (Id. ¶¶ 8-10, 34, 37, 39 & 42.) Hamlin claims he contracted his HCV infection as a result of sharing a razor with his cellmate, James Simonson, who was not informed of his HCV-positive status by PHS while incarcerated in the Maine Correctional Center. (Pl.'s Answer to Interrog. No. 5.) Hamlin also maintains that he was forced to discover that he had tested positive for HCV by researching his own prison records. (Hamlin Aff. ¶ 7.) Hamlin has designated no medical expert to offer testimony to support the allegations that: (a) Hamlin contracted the HCV infection as a result of sharing a razor with James Simonson; (b) the CMS HCV Pathway[2] is unsupported by medical evidence, or is inappropriate to the correctional environment ; (c) the management of his HCV infection has been inappropriate; (d)

Deborah Purrington, does contain more factual detail vis-à-vis the conduct of Dr. Celia Englander and PHS during the period from September 2000 to April 20, 2002, but, again, the Purrington affidavit does not mention HCV treatment nor does Hamlin include citation to specific allegations in that affidavit that would put the defendants on notice as to how Purrington's observations would relate to the facts of this case. Purrington's affidavit contains personal observations of what, in her opinion, was inappropriate conduct by Dr. Englander, but it does not refute the specific medical opinions offered by Englander in her affidavit filed in this case.

[2] The HCV Pathway is a protocol employed by CMS, cited in part by Hamlin's own affidavit, and discussed more fully below.

Hamlin has suffered harm as a result of his HCV infection going untreated; or (e) Hamlin is likely to suffer harm if his HCV infection remains untreated. (Taintor Aff. ¶ 2.)

Hamlin is currently an inmate at the Maine State Prison where he has been incarcerated since March 20, 2002. (Hamlin Aff. ¶ 2.) As long ago as September 1999 Hamlin was housed in Maine correctional facilities. On September 13, 1999, prison authorities transferred Hamlin to an outside hospital for an emergency appendectomy and at that time Hamlin was told a blood test for HCV was negative. (Id. ¶ 31.)[3] Prior to entering the Maine State Prison, Hamlin was housed at the Maine Correctional Center (MCC) in Windham from March 2000 until March 20, 2002. (Id. ¶ 12.) During the time Hamlin was housed at MCC, PHS was the healthcare provider for MCC and Englander was employed by PHS. (Id. ¶ 13.) PHS is a private corporation that contracted with the State of Maine to provide health care services to inmates at the prison. PHS's contract terminated on March 31, 2003, at which time defendant Correctional Medical Services (CMS) took over the contract. (Englander Aff. 1 ¶ 2; Englander Aff. 2 ¶ 1.)

Elevation of serum alanine aminotransferase (ALT), as shown by blood chemistry testing, is a sign of liver cell injury and is typically present in HCV. (Englander Aff. 2 ¶ 6.) Measurement of ALT levels over time is an appropriate first step in the diagnosis of HCV. (Id. ¶ 14.) However, some patients with chronic HCV have normal serum ALT levels, even when tested on multiple occasions. (Hamlin Aff. ¶ 2, Ex. No.1 at 7.) On

[3] Hamlin includes this fact in his affidavit, but does not include it in his statement of material facts and the defendants therefore have not been called upon to admit, deny, or qualify the assertion. However, because this fact is in the nature of background information and does not in any way negatively impact on the defendants' position, I will accept as a fact that Hamlin tested negative for the HCV infection in 1999 and positive for the infection in January 2003 (as is properly established in the undisputed material facts). The inference that Hamlin apparently wants the court to draw, that he developed the infection by using Simonson's razor, simply cannot be drawn without the support of expert medical opinion. Furthermore, the record Hamlin develops does not establish, via admissible evidence, that Simonson ever tested positive for HCV.

January 27, 2002, while incarcerated at the MCC in Windham, Hamlin underwent blood chemistry testing. The test revealed an ALT level of 42, slightly above the upper limit of normal, which is 40. (Englander Aff. 2 ¶ 16.) In Englander's opinion the slightly elevated ALT level reflected in the January 2002 test was not indicative of a hepatitis infection. (Id. ¶ 21.) In Englander's medical judgment immediate investigation and follow-up was not indicated based upon the test result of January 2002. (Id.) Less than half the patients with elevated ALT levels test positive for hepatitis. More often, such test results are associated with a condition called steatosis or "fatty liver." Treatment is seldom, if ever, warranted for patients with persistently normal ALT levels. (Id.)[4]

Hamlin underwent blood chemistry testing on August 26, 2002, which revealed an ALT level of 17, well within the normal range. (Id. ¶ 17.) He underwent blood chemistry testing again on January 27, 2003, which revealed an ALT level of 75. On January 27, 2003, Hamlin also underwent a test for HCV. The result of the test was positive. A confirming test was performed on February 3, 2003. (Id. ¶¶ 19-20.)

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[4] In Hamlin's statement of material facts (Docket No. 136) he denies this singular statement of fact. However, the substance of his denial goes to a dispute regarding conversations he had with Englander regarding his own individualized risk factors for HCV. I think the confusion arises because ¶ 21 of the Englander affidavit (Docket No. 90) contains a great deal more information than the points that were extracted for purposes of the statement of the material facts. The only facts that are undisputed are the ones recited herein. I am satisfied that Hamlin's denial at ¶ 9 (Docket No. 136) does not negate the bare fact that in Englander's medical opinion treatment is seldom warranted for patients with persistently normal ALT levels or that high ALT test results could be associated with "fatty liver." Englander also avers in ¶ 21 that Hamlin denied a history of risk factors associated with HCV. Hamlin points to his intake medical record attached as Exhibit No. 2 to his affidavit as evidence of the fact that Englander knew or should have known that his medical record contained evidence of alcohol, tobacco, and intravenous drug use. According to Hamlin the Center for Disease Control and Prevention recognizes IV drug use as one of the factors that would warrant further testing. Indeed, CMS's own exhibit lists drug use as an important risk factor. (See Englander Aff. Ex. A, Table I.) Hamlin clearly has created a dispute of fact over the issue of whether or not Englander should have identified Hamlin's drug use as a risk factor indicative of HCV infection at the time the first elevated blood test result was obtained in January 2002. I will draw the inference that she should have done so, viewing the record evidence in the light most favorable to Hamlin. Defendants have never offered as a material fact the averment that Hamlin denied a history of risk factors and they have never been called upon to admit, deny, or qualify Hamlin's assertion that Englander should have recognized the risk factor in his medical intake record because the fact is buried in his denial of ¶ 9 of PHS's statement of material fact. In ferreting out this disputed fact I have liberally construed Hamlin's pro se pleading.

The majority of persons infected with HCV are asymptomatic. Sixty to eighty-five-percent of persons infected with HCV develop chronic infection. (Id. ¶ 7.) Only ten to fifteen-percent of those infected progress to serious sequelae including fibrosis leading to cirrhosis, end-stage liver disease of hepatocellular carcinoma. (Id.) In 2003, CMS promulgated a document captioned "Chronic Hepatitis C Pathway," for use by CMS physicians in the evaluation, treatment, and management of patients with chronic HCV. (Id. ¶ 3.) The title page of the HCV Pathway contains the following language:

> *Alert: These Pathways are derived from information in the published medical literature, based upon nationally recognized and/or generally available scientific data in existence at the time of this printing. These Pathways have also been externally reviewed by expert physicians. Clinicians should rely on their own training, skill, and judgment. These Pathways are informational in nature and are not meant to be a substitute for appropriate clinical judgment in the management of individual patients. These Pathways refer to various pharmaceutical agents for use in specific circumstances. The use of these medications should be undertaken only with a full knowledge of potential drug effects in individual patients, based upon thorough review of information in standard prescribing guides and package inserts and knowledge of the individual patient's medical condition. While brand names of medications may be used, this does not imply preference of one drug or drug manufacturer over another.*

(Id. Ex. A at 1.)

The HCV Pathway reflects an approach to the diagnosis and treatment of HCV that is supported by medical evidence as reported in the literature, and is appropriate to the correctional environment. (Id. ¶ 8.) Since the promulgation of the HCV Pathway several inmates at the Maine State Prison have started treatment for HCV. (Id. ¶ 9.) Treatment for HCV is now available to inmates in the Maine State Prison who meet the criteria set forth in the HCV Pathway, as interpreted and applied by professional medical personnel exercising clinical judgment. (Id. ¶ 10.) Section 2 of the HCV Pathway

establishes criteria for evaluating the potential of patients to develop liver disease in the future. (Id. Ex. A at 6-7.)

Section 2, Paragraph 2 of the HCV Pathway defines chronic Hepatitis as liver inflammation for six months or more, as measured by elevated ALT levels. (Id. Ex. A at 6.) Paragraph 2.1.1 recommends that patients with ALT elevations over twice the upper range of normal, during the course of a six month period, should be referred directly for liver biopsy unless anti-viral therapy is contraindicated. (Id.) Section 2, Paragraph 2.1.2 recommends that for patients whose ALT levels are elevated, but are less than twice the upper limit of normal, the decision to obtain a liver biopsy should be made on a case-by-case basis. (Id.) A Consensus Panel of the National Institute of Health has concluded, as the HCV Pathway notes:

> Approximately 30% of patients with chronic HCV infection have normal ALT levels, and another 40% have ALT levels less than two times the upper limit of normal. Although most of these patients have mild disease, histologically, some may progress to advanced fibrosis and cirrhosis. Experts differ on whether to biopsy and treat these patients.

(Id. ¶ 9, Sec. 4 ¶ 3.1.)

A liver biopsy gives the most information about which patients are most likely to progress to cirrhosis and are therefore likely to benefit from treatment. (Id. ¶ 28.) It would be medically inappropriate to perform a liver biopsy, which is an invasive procedure, on a patient who has not first been found to have persistent ALT levels at least twice the upper limit of the normal range. (Id. ¶ 15.) Section 4 of the HCV Pathway establishes the criteria for selection of patients, with an established diagnosis of chronic HCV infection, who are likely to benefit from anti-viral chemotherapy. (Id. Ex. A at 9.) The HCV Pathway establishes ALT elevation as a criterion for the appropriateness of

therapy. (Id. Sec. 4 ¶ 3.) The National Institute of Health Consensus Panel report states, as noted by the HCV Pathway:

> All patients with chronic Hepatitis C are potential candidates for anti-viral therapy. Treatment is recommended for patients with an increased risk of developing cirrhosis. These patients are characterized by detectable HCV RNA levels higher than 50 IU/ml, a liver biopsy with portal or bridging fibrosis, and at least moderate inflammation and necrosis. The majority also have persistently elevated ALT levels. In some patient populations, the risks and benefits of therapy are less clear and should be determined on an individual basis or in the context of clinical trials.

(Id. Ex. A at10, Sec.4 ¶ 3.4.1.)

The medical literature, including literature cited in the HCV Pathway, supports the propositions that:

> · The natural history of chronic Hepatitis C viral infection in patients with normal ALT levels is associated with a delay in the development of severe liver disease; and
> · Patients with asymptomatic chronic Hepatitis C virus infection with persistently normal ALT levels have mild, persistent Hepatitis but little or no tendency for progression of disease.

(Id. ¶¶ 11 & 12; id. Ex. A at 9.)

Section 4, Paragraph 3.2.2 of the HCV Pathway cites a study from the National Institute of Health which shows that the best predictors of fibrosis progression over a twenty-year period are the extent of ALT elevations and the degree of hepatocellular necrosis and inflammation on liver biopsy. This study contains the recommendation that patients with normal ALT levels and mild liver histology can safely defer treatment. (Id. Ex. A at 10.)

Before January 27, 2003, Hamlin had no diagnosis of HCV and the isolated test (on January 7, 2002) showing a slightly elevated ALT did not, in Englander's opinion,

suggest the need for testing to determine whether he was infected with the Hepatitis virus. (Id. ¶ 21.)

According to Englander, the fact that Michael Hamlin's HCV infection was not diagnosed earlier than January 2003 was not the result of any inattention or indifference to his medical condition, but rather the reasonable medical judgment that immediate investigation and follow-up was not indicated based on the test result of January 2002. (Id.) Hamlin underwent further blood chemistry testing on March 10, 2003, which revealed an ALT level of 39, within the normal range. (Id. ¶ 22.) He underwent further blood chemistry testing on May 19, 2003, which revealed an ALT level of 40, the upper limit of normal. (Id. ¶ 23.

Hamlin was seen in the Maine State Prison's Infectious Disease Clinic on May 12, 2003. At this time, he reported "feeling well" and was counseled with respect to his prognosis, the treatment of Hepatitis C, the spread of the disease, and the avoidance of substances harmful to the liver. He was scheduled for follow-up in three months. (Id. ¶24.)

Hamlin's medical record reflects his refusal on several occasions to submit to tests which would establish his ALT levels. These refusals occurred on June 9, 2003, August 18, 2003, August 26, 2003, October 27, 2003, November 12, 2003, and March 10, 2004. On one occasion Hamlin reported that he had been advised by his lawyer to refuse testing. On another occasion he identified the reason for his refusal as a "conflict of interest." (Id. ¶25.)

Hamlin has been seen twice for follow-up in the Infectious Disease Clinic. The management goal established for Mr. Hamlin on these visits has been to obtain his

compliance with blood test protocols to determine his need for treatment. To date, Hamlin has not complied. (Id. ¶26.) At the present time, Hamlin does not qualify for consideration for HCV because he has never been found to have had a period of persistent, significant ALT elevations. (Id. ¶27.) Only upon a finding of persistent, significant ALT elevation would Hamlin undergo a liver biopsy. (Id.) At present, Hamlin's HCV is asymptomatic. (Id. ¶29.) Without a record of persistent ALT elevations and the results of a liver biopsy, it is impossible to predict with any degree of confidence the likelihood that Hamlin's HCV will progress to liver fibrosis or cirrhosis. (Id. ¶30.) If a liver biopsy were performed, the results of the biopsy would dictate whether Hamlin would be offered treatment for his disease. (Id. ¶31.)

Under prevailing standards of practice, a person with "Stage 0" or "Stage 1" hepatitis would not be offered treatment. For such patients, the potential side effects of treatment are generally thought to outweigh any potential benefit it could offer. (Id.) Patients with Stage 0 hepatitis are typically re-biopsied after ten years; patients with Stage 1 hepatitis are typically re-biopsied after five years. (Id.)

Hamlin disputes the assertion that his HCV infection is currently asymptomatic. He avers that because of the severe stress associated with his HCV condition he has had to seek the assistance of mental health services. (Hamlin Aff. ¶ 39.) He is physically drained and always tired because he cannot sleep more than four to five hours a night. (Id.) Hamlin maintains he has lost weight and has had to increase the dosages of his "mental health" medications because of his HCV infection. (Id.) Furthermore, according to Hamlin, small liver spots have developed over his hands, and he associates those spots with his HCV condition. (Id. ¶ 41.) Defendants generally deny these assertions and

point out that Hamlin has failed to identify any expert or other admissible evidence to support the assertion that his HCV infection is the cause of any of the symptoms of which he complains. (CMS Defs.' Reply SMF ¶ 43.)

There is no unwritten CMS policy which in any way contradicts the guidance set forth in the HCV Pathway. (Englander Aff. 2 ¶32.) Englander says there was never any unwritten policy of PHS which prohibited or discouraged the treatment of inmates, as and when appropriate, for Hepatitis. (Id. ¶33.) Hamlin maintains that prior to March 18, 2003, there was simply no program in place to treat HCV. (Hamlin Aff. ¶ 14.)

Englander has not been instructed or urged by PHS or CMS to deny treatment, when appropriate, for Hepatitis C, due to cost considerations or any other reasons. (Englander Aff. ¶34.)

Discussion

Hamlin's Second Amended Complaint seeks monetary and injunctive relief against PHS, CMS, and certain named individuals, including primarily Dr. Celia Englander, alleging both a deprivation of constitutional rights under the Eighth Amendment deliberate indifference standard and a violation of federal law under the Americans with Disabilities Act (ADA), 42 U.S.C. § 12131, et seq. Defendants have each moved for summary judgment, individually, and additionally PHS has joined, to the extent applicable, with the CMS motion. (Docket No. 133). Hamlin alleges that his constitutional rights were violated by the PHS defendants because they deliberately exposed him to an individual known by them to be infected with the HCV infection and therefore caused him to become infected with HCV. He claims that both the CMS and PHS defendants were deliberately indifferent in contravention of the Eighth Amendment

because they failed to adequately diagnose and treat his HCV infection. Englander, who has been employed in a medical capacity by both PHS and CMS, is a party to the pleading of both sets of defendants. Hamlin's ADA claim arises in connection with his claimed HCV "disability."

1. The Constitutional Violation

The United States Supreme Court has framed the broad outlines of the deliberate indifference inquiry in two cases: Estelle v. Gamble, 429 U.S. 97 (1976) and Farmer v. Brennan, 511 U.S. 825 (1994). Estelle identified in the Eighth Amendment protection the "government's obligation to provide medical care for those whom it is punishing by incarceration." 429 U.S. at 103. The Court observed: "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met." Id.; see also Helling v. McKinney, 509 U.S. 25, 32, (1993) ("The substantive limits on state action set by the Eighth Amendment," when it "so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs" including food and medical care).

In Farmer the Court more precisely articulated the standard a plaintiff such as Hamlin must meet to hold a prison official liable for Eighth Amendment claims of this variety. It identified two prongs. The deprivation alleged must be "objectively 'sufficiently serious.'" 511 U.S. at 834 (quoting Wilson v.Seiter, 501 U.S. 294, 298 (1991)); Walker v. Benjamin, 293 F.3d 1030, 1037 (7th Cir. 2002) ("The deprivation suffered by the prisoner must be objectively sufficiently serious; that is, it must result in the denial of the minimal civilized measure of life's necessities," emphasis added). Second, under Farmer, a defendant must have a culpable state of mind, which means that

the defendant was deliberate in his or her indifference to Hamlin's health or safety. Id.; see also Walker v. Peters, 233 F.3d 494, 99 (7th cir. 2000) ("We do not consider what a reasonable doctor would have done. That is an objective test, and Farmer dictated a subjective analysis. Nor is it enough to show that a prison doctor committed malpractice. At the very least, a prison official must act or fail to act despite his knowledge of a substantial risk of serious harm.")(citations omitted). I have employed this analysis in other Eighth Amendment medical care cases, see, e.g., Sirois v. Prison Health Servs., 233 F.Supp.2d 52, 56-57 (D. Me. 2002), and it is the analysis I apply to this factual record.

Hamlin's first salvo pertains to allegations regarding fellow inmate James Simonson, who allegedly was not informed of his HCV-positive status by PHS while he was incarcerated at the Maine Correctional Center. Simonson became Hamlin's roommate at some point in time and Hamlin alleges that he developed his own HCV infection because he shared a razor with Simonson. If supported by admissible evidence, an allegation whereby a prison medical provider deliberately failed to inform an inmate that he had a serious infectious disease that was capable of transmission to others by sharing a razor and then placed that inmate as a roommate with an unsuspecting inmate without the infection, might establish a case of deliberate indifference within the Farmer analysis. See Hutto v. Finney, 437 U.S. 678, 682-83 (1978) (noting, that along with other conditions at the facility, that "some prisoners suffered from infectious diseases such as hepatitis and venereal disease, mattresses were removed and jumbled together each morning, then returned to the cells at random in the evening").

Unfortunately Hamlin has no evidence that any of these things actually occurred. Hamlin does not even have an affidavit from Simonson, and therefore his assertions

regarding Simonson's HCV condition, and his lack of knowledge regarding it, are nothing more than hearsay. Likewise there is nothing in the record that supports the conclusion that sharing a razor, in and of itself, could result in the transmission of HCV infection. See Walker, 233 F.3d at 501, 502 (7th Cir. 2000) (HIV positive and hemophiliac plaintiff must provide competent evidence vis-à-vis impropriety of treatment and injury). Hamlin, as the party with the ultimate burden of proof on these issues, has simply not met his Triangle Trading Co. burden of presenting "specific facts, in suitable evidentiary form" 200 F.3d at 2.

Hamlin's second line of attack relates to the events surrounding the January 2002 elevated ALT test result and the failure of Dr. Englander to order a follow-up test for HCV infection as a result of that single elevated test result. Again, Dr. Englander was employed by PHS at this point. Hamlin does generate certain factual disputes surrounding these events. First he asserts that PHS had no formal program in place for the treatment of HCV inmates.[5] His assertion, coupled with the record's silence on the topic and CMS's detailed presentation of the post-March 2003 program that was put in place gives rise to an inference that PHS lacked a formal program. Hamlin also asserts that Englander knew or should have known that his medical records revealed he possessed the risk factors for HCV. In spite of Englander's statement that Hamlin denied to her that he had any risk factors, this dispute must be resolved in Hamlin's favor at this juncture.

[5] PHS responds to this assertion, found at ¶ 16 of Hamlin's statement of material facts (Docket No.136), by referencing Dr. Englander's affidavit, ¶¶ 16-19, 23, which makes reference to regular testing of Hamlin's ALT levels starting in January 2002 as part of a routine screening. In my mind there is a difference between routine screening and the existence of a treatment program. I will draw this inference in the light most favorable to Hamlin and assume that PHS did not have a treatment program in place. Dr. Englander, however, was familiar with the clinical course of HCV. (Englander Aff. 2 ¶ 5.) The existence of a blood screening procedure from January 2002 forward is undisputed. Hamlin's evidence does not establish that he would have been in a treatment program during this time in any event.

However, even when these disputed facts are resolved in Hamlin's favor, the record still does not reveal facts indicative of the Farmer level of deliberate indifference between January 2002 and January 2003. First and foremost, the record reflects that a follow-up test was performed in August and the results were well within the normal range. Thus even if we assume that Englander was negligent in not ordering more tests in January of 2002, there is absolutely no evidence that Hamlin's condition worsened between then and January 2003 when the HCV confirmatory test was finally performed. This dispute is nothing more than a complaint over the propriety of the course of care undertaken by Englander. This is no more than a dispute about the best course of treatment and such disputes are not actionable under 42 U.S.C. § 1983. See Estelle, 429 U.S. at 107 ("[T]he question whether an X-ray or additional diagnostic techniques or forms of treatment is indicated is a classic example of a matter for medical judgment. A medical decision not to order an X-ray, or like measures, does not represent cruel and unusual punishment. At most it is medical malpractice, and as such the proper forum is the state court."); Gibbs v. Grimmette, 254 F.3d 545, 550 (5th Cir. 2001) ("[T]he general policy of the Bolivar County Jail and Bolivar County Health Department to require testing of only those individuals who show symptoms of active tuberculosis or those who have come into contact with an infected individual does not amount to objective deliberate indifference to the medical needs of pretrial detainees. If Gibbs was exposed to tuberculosis during his incarceration at the facility, then failure of the jail and health department officials to detect an active case of tuberculosis amounted to, at most, negligence, which is not actionable under § 1983.") (citation omitted).

Finally, Hamlin claims that since January 2003 the defendants' deliberate indifference has been manifested by CMS's and Englander's (now in CMS's employ) ongoing refusal to provide him with a liver biopsy and otherwise treat his now confirmed HCV infection as he would like them to treat it.[6] The summary judgment record, set forth in CMS's statement of material facts, clearly sets forth Hamlin's refusal to cooperate with the testing measures they believe are medically necessary before undertaking the more invasive procedure of a liver biopsy, which in turn might lead to a course of drug therapy that would improve his condition. The Seventh Circuit confronted a similar dynamics in Walker, with the inmate and the prison medical staff having reached a similar checkmated position, and it concluded that "no reasonable jury could find the defendants were deliberately indifferent to Walker's serious medical needs simply because they required an HIV confirmatory test before dispensing a powerful and dangerous drug." 233 F.3d at 499 -501. I similarly conclude that based on the record before me no reasonable jury could find an Eighth Amendment violation of Hamlin's constitutional rights apropos this aspect of Hamlin's plaint.

The sole remaining aspect of Hamlin's constitutional claim is his allegation that both PHS and CMS engaged in a custom or policy of denying treatment to HCV patients. Without an underlying constitutional violation, the custom or policy claims fail as well,

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[6] As I indicated, Hamlin chose not to respond to the facts put forth by CMS. Given the coherent manner in which he responded throughout this litigation, I am persuaded that his failure to respond to the allegations concerning his refusal to cooperate with ongoing blood tests was not simply a miscue on his part. For whatever reason Hamlin believes he should have his liver biopsy done and the CMS defendants believe it is not medically necessary. When Hamlin raised this issue with me during a phone conference and indicated that he was going to independently arrange for such a procedure, I indicated that I would make some appropriate arrangement for transportation, even if the CMS defendants refused to certify that it was necessary, if he provided me certification from an outside physician of his own choice that indicated the "appropriateness" of the procedure. He did not pursue that remedy. It is unfortunate that Hamlin's focus on this lawsuit and his unwillingness to cooperate with CMS to submit to the necessary blood work might be actively interfering with Hamlin receiving medical treatment he may actually need and that might improve his condition.

as do any attempts at supervisory liability against Defendants Andrade or Carter. As a threshold matter, claims of entity and supervisory liability "require proof, inter alia, of an underlying constitutional violation." Nieves v. McSweeny, 241 F.3d 46, 50 (1st Cir. 2001); accord Wilson v. Town of Mendon, 294 F.3d 1, 6 -7 (1st Cir. 2002); see also Bowman v. Corrections Corp. of America, 350 F.3d 537, 544-47 (6th Cir. 2003). Because Hamlin has not generated proof of an actual violation of his Eighth Amendment rights by Dr. Englander or any other CMS or PHS health care provider, the entities of CMS and PHS cannot be held liable as the proponents of an unconstitutional policy. And because Defendants Carter and Andrade appear to have been sued exclusively in their capacities as officials in the CMS chain of command, the failure of Hamlin's substantive Eighth Amendment claims entitles them, as well, to judgment as a matter of law.

2. The ADA claim

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. "Pursuant to the plain language of Title II, a plaintiff must establish: (1) that he is a qualified individual with a disability; (2) that he was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability." Parker v. Universidad de Puerto Rico, 225 F.3d 1, 5 (1st Cir. 2000). Title II of the ADA applies to inmates in correctional facilities. Pennsylvania Dept. of Corr. v. Yeskey, 524 U.S. 206, 213 (1998).

CMS and PHS claim they are not susceptible for suit under Title II because they are private entities. (PHS Mot. Summ. J. at 7; CMS Mot. Summ. J. at 11-12). I decline to enter what is for me the difficult legal terrain respecting whether private entities in a position such as PHS or CMS contracted to perform the "services, programs, or activities of a public entity" can escape liability under Title II of the ADA, a question which has not been definitively answered by the Supreme Court. PHS and CMS, as private contractors, argue that Hamlin could only reach them under Title III of the ADA where the only relief available is injunctive remedies. However, providing catering services in a National Park, the example often given of a private entity contracting with the Government and subject to suit only under Title III, seems to me to be substantially different than contracting with the State to assume its constitutional burden of providing for an inmate's basic human needs. It strikes me as doubly difficult when the private contractors such as CMS and PHS claim they are entitled to the procedural protections of 42 U.S.C. § 1997e(e), (PHS Mot. Summ. J. at 1, 8; CMS Mot. Summ. J. at 18), arguing that Hamlin cannot recover monetary damages for mental or emotional injury. It strikes me that PHS and CMS seek to use their status as "private entities" as both a shield and a sword, in one case avoiding the legal responsibilities of state and in the other case assuming the procedural protections granted to state institutions. See Richardson v. McKnight, 521 U.S. 399 (1997) (withholding qualified immunity from private contractors acting as prison guards in state institutions, noting that § 1983 liability might attach, but not § 1983 immunity).

In the end it does not matter in this case because Hamlin does not make out an ADA violation under either Title II or Title III. Hamlin's case is not about discrimination

in any ADA sense. He cannot establish that any medical provider at MCC or MSP has denied him treatment because of a disability. The First Circuit explained in Lesley v. Hee Man Chie:

> [T]he point of considering a medical decision's reasonableness in this context is to determine whether the decision was unreasonable in a way that reveals it to be discriminatory. In other words, a plaintiff's showing of medical unreasonableness must be framed within some larger theory of disability discrimination. For example, a plaintiff may argue that her physician's decision was so unreasonable--in the sense of being arbitrary and capricious--as to imply that it was pretext for some discriminatory motive, such as animus, fear, or "apathetic attitudes." Alexander v. Choate, 469 U.S. 287, 296 (1985); see, e.g., Howe v. Hull, 874 F.Supp. 779, 788-89 (N. D. Ohio 1994) (under ADA, jury could find doctor's diagnosis that plaintiff had extremely rare disorder requiring transfer was pretextual, where patient only had an allergic drug reaction, and doctor did not mention the rare disorder in requesting the transfer but only mentioned plaintiff's HIV-status). Or, instead of arguing pretext, a plaintiff may argue that her physician's decision was discriminatory on its face, because it rested on stereotypes of the disabled rather than an individualized inquiry into the patient's condition-- and hence was "unreasonable" in that sense. See, e.g., Sumes v. Andres, 938 F.Supp. 9, 11-12 (D.D.C.1996) (issuing summary judgment against doctor who refused to treat deaf patient on ground that "all deaf people are high risk," without making any inquiry regarding her specific condition).

250 F.3d 47, 55 (1st Cir. 2001); see also Bryant v. Madigan, 84 F.3d 246, 249 (7th Cir. 1996) ("The ADA does not create a remedy for medical malpractice.").

Here, there is no evidence that Hamlin has been denied treatment for HCV as a consequence of any "discriminatory motive, such as animus, fear, or 'apathetic attitudes.'" Id. In this regard, the fact that CMS has made treatment generally available for inmates with HCV (Defs.' SMF ¶¶ 6 & 7), and the fact that Hamlin's health care needs have been addressed in a variety of ways since his diagnosis (id. ¶¶ 30-34), are both relevant. Id. at 56 ("[A]ny claim that Dr. Chie sought to hide some discriminatory motive is belied by the fact that Dr. Chie had knowingly treated other HIV-positive

patients in the past; likewise, he continued to treat Lesley for some time after learning she was HIV-positive."). This evidence conclusively refutes any suggestion that CMS is engaged in discrimination against HCV-infected inmates as a class, or against Hamlin personally. Nor is there any basis for a finding that Hamlin is being denied treatment because of stereotypical attitudes about his infection. Hamlin does not qualify for treatment because he refuses to submit to blood testing for serum ALT, which CMS deems essential to determine whether treatment is appropriate. (Id. ¶¶ 33-36, 39-40.) And this requirement – that substantial ALT elevation for a sustained period be established as a precondition to treatment – is not one CMS made up, nor one that lacks "any reasonable medical basis." Lesley, 250 F.3d at 57. To the contrary, it is based on a wealth of medical evidence, and it comports with reasonable, appropriate medical practice. (Defs.' SMF ¶¶ 5, 8-21.)

As CMS argues, Hamlin's argument boils down to a contention that the ADA affirmatively requires a certain treatment protocol, or a certain level of health care service, for anyone infected with the HCV. Hamlin believes that everyone infected with the virus is entitled to antiviral treatment and he does not distinguish between individuals whose diseases are symptomatic and asymptomatic nor those who are highly susceptible to progression of the disease and those who are not. This argument cannot be sustained under the ADA.

Even if prior to CMS taking over the medical care, PHS had no program at all for the treatment of HCV, as Hamlin alleges, the absence of a treatment option would not be actionable under the ADA. In that case, everyone in the prison – the "disabled" and the non-disabled – would be similarly situated. The ADA, however, prohibits only

"differentiating between the disabled and the non-disabled." Conners v. Maine Med. Ctr., 42 F.Supp.2d 34, 53 (D. Me. 1999). The fact that treatment is provided for one "disability" (for example, HIV/AIDS) would not require that equivalent, equally effective treatment be provided for disabling Hepatitis C. See id. at 55 ("There is nothing in the ADA that requires that any benefit extended to one category of disabled persons also be extended to all other categories of disabled persons.").

This is not to say that PHS and CMS have no legal obligation to provide treatment for HCV, a serious, potentially life threatening, medical condition. That obligation, however, arises under the deliberate indifference standard of the Eighth Amendment, not the ADA. The fact that CMS now has a treatment program for HCV does not change the analysis. The HCV Pathway promulgated by CMS is neutral, as between the disabled and the non-disabled, in the way it specifies the factors which inform the decision whether and when to treat HCV. The record supports CMS's contention it has adhered to the Pathway in a non-discriminatory way. Neither Hamlin's claim against PHS nor his claim against CMS amounts to ADA actionable discrimination.

Conclusion

Based upon the foregoing, I recommend that the court **GRANT** summary judgment to both PHS and CMS. I also **DENY** Hamlin's motion for a preliminary injunction and motion to strike.

NOTICE

> A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which *de novo* review by the district court is sought, together with a supporting memorandum, within ten (10) days of being served with a copy thereof. A responsive

memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to *de novo* review by the district court and to appeal the district court's order.

December 22, 2004

/s/ Margaret J. Kravchuk
U.S. Magistrate Judge

HAMLIN et al v. PRISON HEALTH SERVICES, INC et al

Assigned to: JUDGE JOHN A. WOODCOCK, JR
Referred to: MAG. JUDGE MARGARET J. KRAVCHUK
Cause: 42:1983 Prisoner Civil Rights

Date Filed: 09/25/2003
Jury Demand: Plaintiff
Nature of Suit: 550 Prisoner: Civil Rights
Jurisdiction: Federal Question

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